

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age in correct age margin. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01995

Reg. Diat. No. 290

## 1. PLACE OF DEATH

County Talbot  
 City or town Easton (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Talbot  
 City or town Easton (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Alexander Brooks

## 3. (b) Social Security Number

15-2-12-9894

4. Sex Male 5. Color of race a.a. 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Pauline Brooks  
 7. Birth date of deceased (mo., day, yr.) Jan 22 1911  
 8. AGE: Years 37 Months - Days 7 If less than one day hrs. min.  
 6.(c) If alive, give age no years

9. Birthplace Easton md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

12. Name George Brooks

13. Birthplace Easton md

14. Maiden name Julia Patten

15. Birthplace Easton md

16. Informant Mr Edatt Brooks

Address Easton md

17. Burial Date thereof Feb 12, 1948 (month) (day) (year)

Cemetery or crematory Richardson

Location Easton md

18. Funeral director James H. Stewart

Address Salisbury md

19. 2/10 19 48 M.H. Neerue (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 19 48 at C.3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19... and that I last saw him alive on 19...

Immediate cause of death Coronary occlusion DURATION

Due to Found dead in truck

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis D. Mitty md DME M. D. or other

Address Easton md Date signed 2-9-48

RECEIVED  
FEB 13 1948  
LD

March 1948 34 11/5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01996

Reg. Dist. No. 290

## 1. PLACE OF DEATH

County TalbotCity or town Milton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah Jane Brooks

4. Sex

F.

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Joseph Brooks

7. Birth date of deceased (mo., day, yr.)

Jan., 31.

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

982

hrs.

min.

9. Birthplace

Talbot Co.  
(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

unknown

FATHER

12. Name

unknown

13. Birthplace

Denise McQuay

14. Maiden name

15. Birthplace

Talbot Co.Ladie Brooks

16. Informant

W. H. H. H.

Address

Buried

(Burial, cremation, or removal, Which?)

Date thereof Feb. 7-1948  
(month) (day) (year)

Cemetery or crematory

St. Michaels

Location

Talbot Co.

18. Funeral director

Leon W. Henry

Address

Eastons Md.19. 2/6/48

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Milton  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 1947 1947 to Feb 7 1948and that I last saw him alive on Jan 25, 1948

Immediate cause of death

arteriosclerotic nephritisuremiaDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivityDue to conclivity

23. SIGNATURE

St. Michaels

Address

St. Michaels

Address

M. D. or other

Date signed 2/5/48

RECEIVED  
FEB 13 1948  
IN READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The Registrar is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01997

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County JA. B. O. T.City or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 hrs.Hospital, institution, or street address where death occurred:  
Easton, MemorialHow long in hospital or institution? 28 hrs.

## 3. (a) FULL NAME

Baby Boy Butler

## 4. Sex

Male

## 5. Color or race

Black

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1948

## 8. AGE:

Years

Months

Days

If less than one day

28 hrs. 1 min.9. Birthplace Memorial Hosp. Easton Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name James Russell13. Birthplace Accomac County Va.14. Maiden name Mildred C. Butler15. Birthplace Caroline Co. Md.16. Informant James RussellAddress Preston Md. P.F.D.17. Burial Date thereof Feb 6 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Pleasant CemeteryLocation Preston Maryland18. Funeral director J. J. Langston Son R.F.D.Address Federalburg Md.19. 2/5 1948 N. H. Merriam  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarolineCity or town Preston  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war. .... ✓

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948 at 2:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/3/48 1948 to 2/4/48 1948and that I last saw him alive on 2/4 1948

Immediate cause of death ..... DURATION

Prematurity 5 1/2 mo. 28 hrsDue to Unknown

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

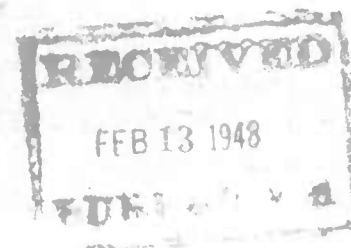
Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. T. B. Ambler M. D. or otherAddress Easton Md Date signed 2/6/48



Evidence for addition of age and birth date shown on:

FILM No. G 115 MAY 7-1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01998

Evidence for addition of marital status shown on:  
FILM No. 5 11 APR 12 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Talbot  
City or town... Easton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 days  
Hospital, institution, or street address where death occurred:  
Easton Memorial Hospital  
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Talbot  
City or town... Whitman Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

3. (a) FULL NAME

Charlie Cooper

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male colored W

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age .....

7 Approx. 1883

8. AGE: Years Months Days If less than one day  
approx. 65 .....

9. Birthplace... Talbot County  
(Town, county, and state)

10. Usual occupation... Waterman

11. Industry or business

12. Name... James Cooper

13. Birthplace... Talbot County

14. Maiden name... Elizabeth Warner

15. Birthplace... Talbot County

16. Informant... William Cooper

Address... Whitman, Md.

17. Burial Date thereof... 2/29/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... McDaniel

Location... McDaniel Md

18. Funeral director... Len McHenry

Address... Easton Md.

19. 2/27 48 N.H. Newnes  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 27 19 48 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-21 19 48 to 2-27 19 48

and that I last saw h... alive on ... 19...

Immediate cause of death ... DURATION

Hemorrhage 2 days

Due to... Transurethral Resection

Due to... Hypertrophied Prostate

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations... Hypertrophied Prostate Date of op. 2/25/48

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of 2/27/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. Cox M.D.

Address... Easton Md. Date signed...

MARGIN RESERVED FOR BINDING

I

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 16 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County GalbottCity or town Rural Eastern Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John Samuel Covey

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) 1876

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Galbott Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal) Which? Feb. 19, 1948

Cemetery or crematorium

Location

18. Funeral director

Address

19. 2/17 48 N.H. Merriam

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MarylandCounty GalbottCity or town Rural Eastern

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1619 48 at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1319 48 to Feb. 1619 48and that I last saw him alive on Feb. 1519 48

Immediate cause of death

Hemiplegia leftGeneralized ext. seizure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

FEB 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Subs  
 City or town Rural Cordova  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ms County Subs  
 City or town Rural Cordova  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

James Dulin

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Gertrude A. Dulin

7. Birth date of deceased (mo., day, yr.) March 25, 1871 6.(c) If alive, give age..... years

8. AGE: Years 76 Months 10 Days 17 It less than one day..... hrs. .... min.

9. Birthplace Subs County, Md.  
 (Town, county, and state)

10. Usual occupation Blind Farmer

11. Industry or business

12. Name Wm B. Dulin Jr.

13. Birthplace Ms

14. Maiden name Stephen Bayles

15. Birthplace Ms.

16. Informant Mrs. Wendon Dulin

Address Cordova. Ms.

17. Burial Date thereof Feb 90, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Cordova Ms.

18. Funeral director Robert Clark

Address Cordova Ms.

19. 2/7 19 48 N.H. Morris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 19 48 at 10:29 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12-1 - 19 46 to 2-7 19 48

and that I last saw him alive on 2-6 19 48

Immediate cause of death..... DURATION

Broncho pneumonia 16 days

Due to.....

Due to.....

Other conditions Hypertension

General art. scl. hyp  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

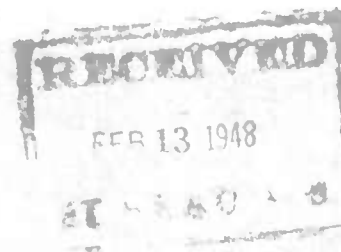
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE W. F. Buell M. D. or other

Address Cordova Ms Date signed 2-7-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County *Charles*  
 City or town *Rural Eastern*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *5 days*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Johns*  
 City or town *Louis Mills Rural Eastern*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

*Louis Fitzgerald*  
 4. Sex *M.* 5. Color or race *W.* 6.(a) Single, married, widowed, or divorced *M.*

## 3.(b) Social Security Number

6.(b) Name of husband or wife *Wm Fitzgerald*  
 6.(c) If alive, give age *84* years

7. Birth date of deceased (mo., day, yr.) *Sept. 4, 1861*

8. AGE: Years *86* Months *5* Days *5* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Germany*  
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business \_\_\_\_\_

12. Name *Augusta Davis*

13. Birthplace *Germany*

14. Maiden name *Unknown*

15. Birthplace \_\_\_\_\_

16. Informant *Mr. Herman Davis*

Address *Eastern Md.*

17. *Burial* Date thereof *Feb. 11, 1948*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Spring Hill*

Location *Eastern Md.*

18. Funeral director *Robert Clark*

Address *Eastern Md.*

19. *2/10* 19 *48* *W.H. Morris*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 9* 19 *48* at *6:35* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *2/4/48* to *2-9-48* and that I last saw him alive on *2-8-48*

Immediate cause of death \_\_\_\_\_ DURATION *7*

*Arteriosclerosis, generalized*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *B. Cox M.D.*

M. D. or other

Address *Eastern Md.* Date signed *2-10-48*

RECEIVED

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 294

1. PLACE OF DEATH: Talbot.  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland, County Talbot  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
Mary Francis Grace

3. (b) Social Security Number

4. Sex 7. Color or race 8. (a) Single, married, widowed, or divorced  
7. Color or race 8. (a) Single, married, widowed, or divorced  
6. (b) Name of husband or wife Robert H. Grace  
6. (c) If alive, give age 68 years  
7. Birth date of deceased (mo., day, yr.)  
8. AGE: Years Months Days It less than one day

9. Birthplace Talbot Co. Md.  
(Town, county, and state)  
10. Usual occupation Housewife

11. Industry or business

12. Name Robert H. Henson

13. Birthplace Talbot Co.

14. Maiden name Maria M. Freeman

15. Birthplace Talbot Co.

16. Informant Robert H. Grace

Address Wittman Md.

17. Burial Date thereof 2/10/1948  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or ossuatory Wittman Md.

Location Wittman Md.

18. Funeral director Leon W. Henry

Address Easton Md.

19. Feb 10 1948 G. Wesley Swell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1948 to Feb 1948 and that I last saw him alive on Dec 1947

Immediate cause of death coronary atherosclerosis 5 min

Due to arteriosclerosis, hypertension 2 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

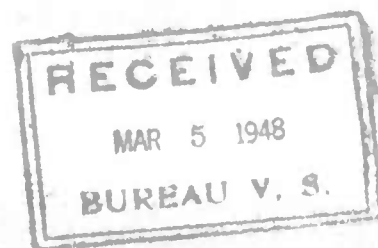
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Guy W. Reeves Md.

Address T. H. Wittman Md. Date signed 2/10/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02003

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 132 daysHospital, institution, or street address where death occurred:  
Eastern Memorial HospitalHow long in hospital or institution? 132 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Vivian Holmes

## 3.(b) Social Security Number

4. Sex F 5. Color or race B 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Ned Nathaniel Holmes7. Birth date of deceased (mo., day, yr.) March 2, 1928 B.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 19 Months 11 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Balt. Md  
(Town, county, and state)10. Usual occupation Cannery

11. Industry or business \_\_\_\_\_

12. Name Wm Doper13. Birthplace Pa14. Maiden name Ida Parker15. Birthplace N. Carolina16. Informant Ned Nathaniel HolmesAddress Easton Md17. Removal Date thereof 2/20/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Baltimore Md18. Funeral director Sarah L Brown SonAddress 10866 Mount Omy St2/20 48 N.H. Holmes

19. (Date rec'd by registrar) \_\_\_\_\_ Registrar \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948, at 8 a.m. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1947 to 19 Feb 1948and that I last saw h. cr alive on 19 Feb 48 1948Immediate cause of death Respiratory Paralysis

DURATION

Due to Cervical DislocationDue to 5th Cervical Fracture of cervical cord.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Dislocation of Cervical vertebrae

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto accident Date of 12 Oct 47Where did injury occur? West Haverford Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Cause of injury Auto accident Injured at work? \_\_\_\_\_23. SIGNATURE Sgt. Kormanis MD. M. D. or other \_\_\_\_\_Address Easton, Md. Date signed \_\_\_\_\_

RECEIVED

FEB 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 minutes  
 Hospital, institution, or street address where death occurred:  
to 1577.71 Hosp.  
 How long in hospital or institution? 15 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Queen Anne  
 City or town Pasoville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

Baby Jay Jackson

## 3. (b) Social Security Number

4. Sex m 5. Color or race C 6.(a) Single, married, widowed, or divorced S

## 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 2/7/48 - 5.45 PM 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Year \_\_\_\_\_ Months \_\_\_\_\_ Day \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. 15 min.

9. Birthplace Talbot County  
 (Town, county, and state)

10. Usual occupation None

## 11. Industry or business

12. Name Warner Hatten

13. Birthplace Virginia ✓

14. Maiden name Usci King

15. Birthplace Maryland

16. Informant Usci Jackson

Address Pasoville, Md

17. Cremation Date thereof 2/7/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Hospital

Location Easton Md

18. Funeral director Memorial Hospital

Address Easton Md

19. 2/7 19 48 D.H. Norris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/48 19 48, at 600 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/7 19 48, to 2/7/48 19

and that I last saw him alive on 2/7/48 19

Immediate cause of death Prematurity

Due to unknown

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

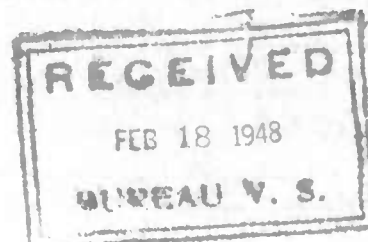
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Meane of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J.T.B. Ambler MD M. D. or other

Address Easton Md Date signed 2/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02005

183

Reg. Dist. No. 294

## 1. PLACE OF DEATH:

County Calvert  
 City or town Choptank River  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? near Long Point  
 Hospital, institution, or street address where death occurred  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert  
 City or town Choptank River  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Kenneth J. Malkin

## 3. (b) Social Security Number

215-26-4017

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) Aug. 27-1901  
 8. AGE: Years 46 Months 5 Days 19 If less than one day  
 hrs. min.

9. Birthplace Hearney - Ontario - Canada  
 (Town, county, and state)  
 10. Usual occupation Waterman  
 11. Industry or business Optics Buyer  
 12. Name Edward Malkin  
 13. Birthplace Tingely - England  
 14. Maiden name Elizabeth - Mann  
 15. Birthplace Embs - Ontario - Canada

16. Informant Miss Grace Malkin  
 Address 98<sup>th</sup> Ontario Rd - Toronto - Ont.  
 17. Burial Date thereof Y 19 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Amelbury - Highman M.E.  
 Location Highman - Md.  
 18. Funeral director Mr. John L. Moore  
 Address Highman - Md.  
 19. 219-48 19 Highman L  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION 48

20. DATE OF DEATH Feb 16 1948 at 5 P M  
 21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb 16 1948 to Feb 16 1948  
 and that I last saw him alive on Jan 1948  
 Immediate cause of death Drowning (accidental) intensity  
 DURATION  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE James Reeser M. D. or other  
 Address Highman Md Date signed Feb 16 1948

RECEIVED

MAR 5 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

290

### 1. PLACE OF DEATH:

County Baltimore  
City or town Royal Oak  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life  
Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore  
City or town Royal Oak md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. no  
(If rural, give LOCATION)

2.(a) If veteran, name war no

### 3. (a) FULL NAME

Wilgena D Moore

### 3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

a.g.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Joseph Moore

7. Birth date of deceased (mo., day, yr.)

Oct 6 1882

6.(c) If alive, give age Don't know years

8. AGE:

Years

Months

Days

If less than one day

65

hrs.

min.

9. Birthplace

Baltimore  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

same as above

FATHER

12. Name

unknown

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Joseph Moore

Address

Royal Oak md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb 25 48  
(month) (day) (year)

Cemetery or crematory

Royal Oak

Location

Royal Oak md

18. Funeral director

James H. Stewart

Address

Salisbury md

19.

(Date rec'd by registrar)

19 48

W. H. Nevin Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 25

19 48

at 5:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 47 to Feb 25 19 48

and that I last saw her alive on Feb 25 19 48

Immediate cause of death

Carcinoma of the Cervix

DURATION

2 yrs

Due to

Due to

Other conditions

Diabetes Mellitus  
(Include pregnancy within 3 months of death)

3 yrs

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harvard T. Webb M.D.

M. D. or other

Address

Easton, Md.

Date signed 2/26/48

MARGIN RESERVED FOR BINDING

9-45-5M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **290**

**1. PLACE OF DEATH**  
 County Talbot  
 City or town outside Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? minutes  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State Md County Talbot  
 City or town Easton - rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

**3. (a) FULL NAME** Charles Glenn Patchett  
**3. (b) Social Security Number**

**4. Sex** M. **5. Color or race** W. **6. (a) Single, married, widowed, or divorced** S.

**6. (b) Name of husband or wife** \_\_\_\_\_  
**6. (c) If alive, give age** \_\_\_\_\_ years

**7. Birth date of deceased (mo., day, yr.)** Jan 24, 1931

**8. AGE:** Years 17 Months 0 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

**9. Birthplace** Georgetown, Delaware  
 (Town, county, and state)

**10. Usual occupation** Employed by Coca Cola Company

**11. Industry or business**

**12. Name** Charles A. Patchett

**13. Birthplace** Md.

**14. Maiden name** Anne May Price

**15. Birthplace** Md.

**16. Informant** Charles A. Patchett

**Address** Easton, Maryland

**17. Burial** Burial Date the February 9, 1948  
 (Burial, cremation, or removal. Which?) (month) (year)

**Cemetery or crematory** Greenwood

**Location** Academy, Maryland

**18. Funeral director** W. H. Beck

**Address** Easton, Md

**19.** 2/7 48 N.H. Nevers  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

**20. DATE OF DEATH** February 6 1948, at 6:17 P.M.

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

**Immediate cause of death** accidental drowning  
 Due to into accident  
 Due to shutted on ice  
 Other conditions ? fr. arr. spine  
 (Include pregnancy within 3 months of death)

**Major findings of operations** \_\_\_\_\_ Date of op. \_\_\_\_\_

**Autopsy results** \_\_\_\_\_  
**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide accident Date of 2-6-48  
 Where did injury occur? outside Easton Md. (County) (State)  
 Injured at home, farm, industry, pub'c place (where?) public road  
 Means of injury into accident Injured at work? No

**23. SIGNATURE** Louis S. Witty, M.D. J. B. K.  
 Address Easton Md Date signed 2-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 13 1948  
AT 11:40 A.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 292

02008

## 1. PLACE OF DEATH:

County Talbot  
 City or town Oxford (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all of life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Talbot  
 City or town Oxford (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Martin James Pinder

## 3.(b) Social Security Number

215-14-3819

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Isabelle Pinder  
 6.(c) If alive, give age 65 years  
 7. Birth date of deceased (mo., day, yr.) Sept. 3, 1878  
 8. AGE: Years 69 Months 5 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Trappe  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business

12. Name Thomas Pinder  
 13. Birthplace Trappe  
 14. Maiden name Mary E.  
 15. Birthplace Trappe Md.

16. Informant Isabelle Pinder  
 Address Oxford Md (Rural)

17. Burial Date thereof Feb. 24, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Trappe Rural (Private)  
 Location Trappe Md

18. Funeral director Maxine E. Newman & Da  
 Address Easton Maryland

19. Set md 1948 Joseph Bono Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1948, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14, 1948, to Feb. 18, 1948  
 and that I last saw him alive on Feb. 17, 1948

Immediate cause of death Hemiplegia right days  
Generalized arteriosclerosis yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

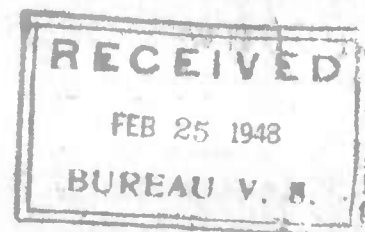
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE M. F. Bunt M.D. or other  
 Address Easton Md Date signed 2-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lida Shataon Riley

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow  
 6. (b) Name of husband or wife John Henry Riley  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 21, 1863  
 8. AGE: Years 84 Months 8 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mecklenburg, Virginia  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name James Farson Watson13. Birthplace Winchester, Virginia14. Maiden name Anne Garrell15. Birthplace Winchester, Virginia16. Informant Miss Cora RileyAddress Easton, Maryland17. Burial Date thereof Feb. 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Stonewall Memorial ParkLocation Saulsbury, Md18. Funeral director Maurice E. Newman, SonAddress Easton, Md19. 2/26 19 48 N.H. Neerix  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1948 at 8:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Feb. 1948and that I last saw him alive on Feb. 24th, 1948Immediate cause of death Coronary heart DURATION 8 yrs.mitral regurgitation

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William S. Symmes M. D. or other \_\_\_\_\_Address Easton, Md. Date signed 2/25/48

RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

## 1. PLACE OF DEATH:

County... **Talbot**  
 City or town... **Bellevue**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **From 1.12.48 to 2.11.48**  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? **#####**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... **Maryland** County... **Talbot**  
 City or town... **Bellevue**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2(a) If veteran, name war... **#####**

## 3. (a) FULL NAME

**william Alfred Smith**

## 3. (b) Social Security Number

**#####**

4. Sex **Male** 5. Color or race **col** 6. (a) Single, married, widowed, or divorced **Infant**  
 B. (b) Name of husband or wife **#####**  
 7. Birth date of deceased (mo., day, yr.) **1.12.48** 6. (c) If alive, give age **#####** years  
 8. AGE: Years Months Days If less than one day  
**29 30** hrs. min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH... **Feb. 11, 1948** 19... at **6:10** a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**Feb. 11, 1948** 19... to **Feb. 11, 1948**  
 and that I last saw him alive on **1.12.48** 19...

Immediate cause of death... **Asthenia**  
 DURATION  
**30 days**

Due to... **undetermined**

Due to...

Other conditions... **Emaciation (extreme)**  
**Pregnancies to close together**  
 (Include pregnancy within 3 months of death)

Major findings of operations... **None**Date of op. **None**Autopsy results... **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... ☒ Date of ☒Where did injury occur? ☒ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ☒ Injured at work? ☒23. SIGNATURE **Philip B. Smith** M. D. or otherAddress **St. Michaels, Md** Date signed **2.11.48**

9. Birthplace... **Bellevue, Maryland.**  
**None** (Town, county, and state)  
 10. Usual occupation... **None**  
 11. Industry or business **#####**  
 12. Name... **Jno. Lester Smith**  
 13. Birthplace... **Bellevue, Md**  
 14. Maiden name... **Gladys C. Banks**  
 15. Birthplace... **Balto. Maryland.**  
 16. Informant... **Jno. L. Smith**  
 Address... **Bellevue, Md**  
**Burial** Date thereof... **2.11.48**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory...  
 Location... **Deep Neck, Maryland.**  
 18. Funeral director... **Jno. L. Smith**  
 Address... **Bellevue, Md**  
 19. **2/11** **48** **Mrs. Robt. L. Smith**  
 (Date rec'd by registrar) 19... Registrar

RECEIVED  
FEB 13 1948  
BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

asymptomatic 1.20.49

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02011

Reg. Dist. No.

290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Low 20.1.48 to Feb 21-1948

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? Jan. 20, 1948 to Feb 21-1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Caroline Co.City or town Low 20.1.48 to Feb 21-1948  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Bartha Taylor

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female col. Widowed6. (b) Name of husband or wife Wilson7. Birth date of deceased (mo., day, yr.) Nov 7, 1887

8. AGE: Years Months Days If less than one day

60 hrs. min.9. Birthplace Caroline County  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Alfred Taylor13. Birthplace Caroline County14. Maiden name Julia Woodland15. Birthplace Queen Anne County16. Informant Edith TaylorAddress Greensboro, Md.17. Burial Date thereof 2/25/48  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory EastonLocation N. H. Rawlings18. Funeral director R. B. RawlingsAddress Greensboro, Md.19. 2/29 48 N. H. Rawlings  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-1948 at 11:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-20-1948 to 2-20-1948and that I last saw her alive on 2-20-1948Immediate cause of death ExhaustionDue to Carcinoma of stomachDue to Carcinoma of stomachOther conditions Carcinomatous arteries & sclerosis  
(Include pregnancy within 3 months of death)Major findings of operations C. of stomachC. of stomach Date of op. 2/9/48Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. H. Rawlings M. D. or otherAddress Easton Md. Date signed \_\_\_\_\_

RECEIVED

FEB 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02012

Reg. Dist. No. 29

## 1. PLACE OF DEATH:

County Bel Air  
 City or town Bel Air, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long above place of death? 10 days  
 Hospital, institution, or street address where death occurred:  
Bel Air Memorial Hospital  
 How long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Queen Anne's  
 City or town Potter  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mr. John Thomas

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

W.

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

Dec 25, 1868

## 8. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

19

hrs.

min.

## 9. Birthplace

Chester, Queen Anne Co., Md.

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. (Burial, cremation, or removal, which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. (Date rec'd by registrar)

## 20. DATE OF DEATH

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

## and that I last saw him alive on

## Immediate cause of death

## DURATION

## Due to

## Due to

## Other conditions

## (Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

## Where did injury occur?

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

## M. D. or other

## Address

## Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1948 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/6 1948 to 2/16/1948

and that I last saw him alive on 2/16/1948

Immediate cause of death

arteriosclerosis, generalized

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Dates of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 2-17/48

RECEIVED

FEB 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02013

Reg. Dist. No. 592

## 1. PLACE OF DEATH:

County TalbotCity or town Trappe  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? All of life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County TalbotCity or town Trappe  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph Jones Warner

## 3. (b) Social Security Number

+

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Laura L Warner6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) Apr. 3, 18748. AGE: Years 73 Months 10 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Trappe Talbot Co. Md.  
(Town, county, and state)10. Usual occupation Farmer (Retired)

11. Industry or business \_\_\_\_\_

12. Name John R. Warner13. Birthplace Talbot Co. Md.14. Maiden name Eliza Jones15. Birthplace Talbot Co16. Informant Mr. Edward WarnerAddress Easton Md.17. Burial Date thereof 2/24/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring HillLocation Easton Md.18. Funeral director Maurice E. ThompsonAddress Easton Md.19. Per md 1948 Joseph Abcox  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1948 at 3:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14, 1948, to Feb. 21, 1948and that I last saw him alive on Feb. 20, 1948Immediate cause of death acute coronary thrombosis DURATION 8 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

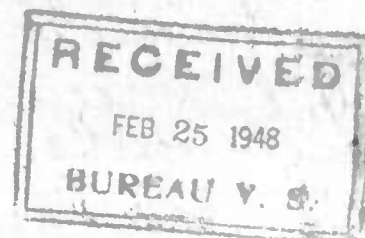
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William J. Seymour M. D. or other \_\_\_\_\_Address Trappe Md. Date signed 2-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Lach  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Feb  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Lach  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Samuel Amos Warner

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Jan 11, 1883 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 65 Months 0 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Lach County  
 (town, county, and state)

10. Usual occupation Mechanics (Paint & Carpenter)

## 11. Industry or business

12. Name Samuel A. Warner

13. Birthplace MD

14. Maiden name Mary Elizabeth Wolf

15. Birthplace MD

16. Informant Samuel A. Warner

Address Easton, MD

17. (Burial, cremation, or removal Which?) Burial Date thereof Feb. 17, 1948  
 (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton, MD

18. Funeral director Robert Clark

Address Easton, MD

19. 2/10 48 N.B. Neer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 19 48 at 12:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 47 to Feb 19 48

and that I last saw him alive on Feb 9 19 48

Immediate cause of death Valvular heart disease, mitral stenosis DURATION 3 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Antepartum results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thelma S. Seymour M. D. or other \_\_\_\_\_

Address Easton Md Date signed 2-11-48

RECEIVED

FEB 18 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The subject's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02015 290

## 1. PLACE OF DEATH

County Talbot  
 City or town Loupswood  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

George Harry Wion

7. Birth date of

deceased (mo., day, yr.)

May 13-1887

8. AGE:

60

Years

Months

Days

If less than one day

min.

9. Birthplace

Jacksonville, Pa.

10. Usual occupation

Retired

11. Industry or business

George H. Wion

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

MOTHER

16. Informant

Address

17. (Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

Immediate cause of death

DURATION

One to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

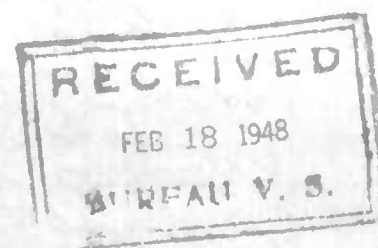
Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03145

Reg. Dist. No. 292

## 1. PLACE OF DEATH:

County TALBOT  
 City or town TRAPPE (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? ALL OF LIFE  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD. County TALBOT  
 City or town TRAPPE (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ROBERT MATHEW YOUNG

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race COLORED 6. (a) Single, married, widowed, or divorced SINGLE  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) JUNE 18 - '47  
 8. AGE: Years \_\_\_\_\_ Months 8 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace TRAPPE, MD.  
 (Town, county and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name HERMAN YOUNG  
 13. Birthplace FRYTOWN, MO.  
 14. Maiden name BEATRICE YOUNG  
 15. Birthplace TRAPPE, MD.

16. Informant HERMAN YOUNG  
 Address TRAPPE RD.

17. BURIAL Date thereof 3-1-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory FRYTOWN CEMETERY  
 Location FRYTOWN, MO.

18. Funeral director JOHN D. WILLIAMS  
 Address EASTON, MD.

19. 3/1 19 48 TRAPPE  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 28 19 48 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-27 19 48, to 2-28 19 48  
 and that I last saw him alive on 2-27 19 48

Immediate cause of death Cerebral Irritation DURATION 1 day  
Upper Respiratory Infection 1 week  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. J. Bullard M. D. or other \_\_\_\_\_

Address Easton Md Date signed 2-28-48

RECEIVED

MAR 12 1948

BUREAU V. S.